Community Hospital Task Force II
Meeting #8 Notes
March 11, 2008
Rhode Island Department of Administration
Conference Room A, 1 Capitol Hill, Providence

Commissioner Koller began the meeting and reviewed the agenda. He stated that at the last meeting, we discussed Medicaid's payment methodology for hospital inpatients, and the effects of policy adjusters. Task Force members raised concerns about the work of the Task Force (its content and direction) and the financial health of hospitals. Task Force gave feedback that there needs to be a focus on commercial and RIte Care options for payment as well.

Commissioner Koller directed attendees to the hand out of a powerpoint presentation, top slide on page 2. This slide reviewed the CHTF workplan since November – the elements of a Medicaid payment method that have been discussed and the discussions of how these elements may be applied to other payers.

The Task Force then turned to page 5 of the handouts – why did the CHTF get the charge to examine payment? Koller made the point that the Task Force is now discussing commercial payment because Medicaid is only 7% of the community hospitals' overall inpatient population, and Task Force cannot affect Medicare FFS payments.

Last year's data on the variation that hospitals are paid for similar inpatient services is shown on page 6. It is partially complete (i.e., does not include data on outpatient payment amounts.) When presented to the Task Force last year, this slide raised concern because of the significant variation and lack of consistency across payers. The "fairness" principle emerged out of this conversation. Task Force members believed that the disparity of payment may be driving the financial health of hospitals.

One Task Force member raised the question of whether this data on payment levels from commercial payers is available to the state – the answer is no, commercial payers' payment levels are proprietary information.

Commissioner Koller then turned to the slide on the bottom of page 7. He pointed out that RIte Care would be the next logical step when considering a change in payment methodology, but that at an earlier meeting we heard that there were two concerns from the RIte Care program: 1) Haven't historically imposed conditions on plans' negotiations with providers, and 2) Don't want to increase program costs – a different base rate and different policy adjusters would be necessary for the RIte Care population.

Commissioner Koller then turned to Attachment 4, the document titled "RIte Care/Commercial Rate Oversight Options", and oriented the group to the information presented. Each row describes some criteria of different payment models: whether it would address "fairness", how it addresses other concerns of the CHTF, what the long-term system cost would be, what the effects are on clinical quality and population health, and state resources needed to implement.

The columns present different models: 1) private negotiations (status quo), 2) disclosed negotiations, 3) state adopts a payment methodology – payers negotiate base rates privately, then disclose them – this system makes it easier to compare base rates, 4) private negotiations with veto by state – this would increase state authority, because rates could be dismissed, 5) use budget determination mechanism to adopt a requirement to pay a certain percentage of Medicare, and 6) rate-setting commission like Maryland.

In summary, there are different variations along this continuum – as you move across the table to the right, the greater the state's role. You usually see the state increase its role when fairness and equity are important, but defer to competition when choice is an issue.

The question is: What is the Task Force's appetite for using oversight of payment in the commercial setting?

One Task Force member raised the concern that it is unfair to present this document when it was developed without input from the group, with no back-up information, and some biased assertions. It is not for a layman, and there is no chance to consult with others before discussing it. Another Task Force member took the opposite position – that it in fact was appropriate to present this range of options.

The first Task Force member responded by questioning how the Task Force can make a decision on a model without a health plan first. Another member commented that there would be some value in discussing models, but also that it is frustrating that there is no state health plan. Concern is that changing the status quo is not the answer to what community hospitals need, and it could be inflationary, unless you do rate-setting, which is troubling given its political nature.

Discussion turned to planning. Another Task Force member agreed that we have to decide what we want (what services, what care model) and it's hard to do it piecemeal. At one point, this member thought that the Task Force would decide if all community hospitals should remain – and then decide what actions could be taken to support those hospitals. Not sure if we have the resources or the mandate to do the planning – so the CHTF may no longer be useful. The CHTF should not have anything more to do with Medicaid. Community hospitals need to preserve their own agenda and advocate for themselves.

Discussion then turned to state oversight of insurers. Comment raised that the state does not have information to determine whether hospital is being treated fairly by payers or not. This Task Force member expressed support for transparency of detailed quality information from hospitals along with reimbursement from payers. Comment was made that the RI Business Group on Health has been discussing this type of transparency since 1983 – and stopped when managed care came. Business community has been asking for cost, price, and reimbursement transparency. Hospitals and physicians have been against that transparency, citing privacy and burden of data collection. Transparency would at least let low-cost efficient hospitals see disparity resulting from negotiations. Wouldn't want the state setting rates.

Another Task Force member pointed out information about hospital costs, referencing earlier reports from the Department of Health that show that hospitals have been ranked by cost – and hospitals have held the same ranking for a long time. Differences in cost structure have been in place for years – why does the differential in cost exist? Should be a question to be looked at. Another Task Force member suggested that the current sense of urgency could mean that we need a fresh look at this – results of history doesn't address the change we need today – need to be open to new things.

This discussion of costs prompted a parallel between RI and NJ. The Commission on Rationalizing Health Care in NJ criticized the hospital payment mechanism, but urged taking a look at model itself and efficiency of hospitals before looking at payment. We need to deal with endemic causes. The relationship with physicians has deteriorated – are there opportunities to turn that around? It's in the hospitals hand – but the hospitals will say it's in the payers' hands. If you're a procedure-based physician, you can do very well. Can a payer have any impact?

Commissioner Koller reiterated the question before the Task Force: do they advocate for more comprehensive review, or is there a degree of urgency such that there's not time for planning? Choices are a) comprehensive planning, or b) interim steps – go to the far right of table and make a change.

One Task Force member advocated for taking a look at hospitals in trouble and finding ways of stabilizing the crisis – have payers do it. Also have argued in the past for transparency of payment – it's worth taking the risk – and then have to do planning. Another suggested that increasing transparency is another type of short-term action. Yet another member pointed out that the Task Force has been saying all along that there needs to be short-term and long-term action. Transparency would help things initially.

With regard to a "blue ribbon" committee to do planning or otherwise, the concern was raised that it could not get us beyond an infusion of funds – and that would be reflected in insurer rates. Director of Health David Gifford commented that the health planning statute passed, and the Dept. is prepared to do planning – but it is not beyond issue #3 or #4 on the priority list for funding – if this was really going to fix community hospitals – then need to advocate for that. Response was that the community has not yet tried to build a coalition for funding health planning, but that first-order requests would be for money for short-term survival.

More discussion of planning included the perspective that some hospitals believe that even if some services are outdated, but they should provide those services because their communities need us to. Until we determine what those needs actually are, how do we determine what services hospitals should have?

Koller: Landmark Medical Center is closest to the edge, and South County and Westerly are on the same path but not as close. Question is how much time do these hospitals have, and are they sure enough of their short-term survival to participate in long-term planning. Does anyone advocate that the crisis is not extreme enough?

Comparison with NJ was raised again – there, three hospitals had closed and people became concerned, but they still produced a report that was not significant. Who's going to have the guts to implement findings if we do something similar?

Question raised - is it the responsibility of state government to intervene if hospital is doing low-volume of services? Response was that there are different reasons why hospitals are in trouble – it's not just about cost. Would advocate for more transparency for hospitals – maybe this is the time to go into hospitals' books. Another Task Force member argued that transparency should work both ways –i.e., transparency in payment too.

Suggestion was made for a 2-part charge for going forward: 1) Stabilize hospitals (put it up to payers), 2) Get a comprehensive health plan. Another suggestion to add a 3rd item – transparency of payment.

Task Force members then discussed a 'stabilization' committee. Comment that there would be disagreement on how stabilization would happen. Another comment that stabilization could hurt a payer, and payers can't work together on this issue. One Task Force member mentioned that a panel in New York City looked at whether hospitals should be providing services – and opened their books. Comment made that BCBSRI has stated that they wouldn't be interested in stabilizing the status quo. TF members had general agreement that any stabilization funds would come "with strings attached." Commissioner Koller asked the group to discuss what the process is for a discussion on stabilization – is it a private

discussion? Another Task Force member suggested that payers and business should be involved.

A representative from a payer suggested that both these recommendations fall to the payers to fund. For example, if there is a "Blue Ribbon" commission to discuss where system should be going – BCBSRI would fund transformation. Question raised – who determines what transformation is? Suggestion made that the state is the only one with enough clout to do that. Another suggestion was to look to the Coordinated Health Planning Advisory Council's recommendation – create a planning board. For the stabilization committee, it would be payers and businesses.

Comment made in favor of planning – for example, the hospitalist movement has emerged with no planning. If we let the market decide, this is what happens – and we're just now starting to see the consequences of the hospitalist program. We have a chance now to look at all systems and decide what a community needs. Another comment advocated for greater planning to meet the need for primary care physicians. For example, PCPs' relationship with the hospitals has changed.

Commissioner Koller asked the group whether there was anyone advocating for a geographically-limited plan (for example, a plan for Washington County.)

Response from group was negative – need a statewide plan, especially with a proposed merger that would affect the whole state. Additional comment made that only long-range planning can solve the problem of competition.

Suggestion that the next step is to work out details how three components would be done: 1) stabilization committee (broad agreement), 2) comprehensive planning (broad agreement), and 3) price transparency (mixed agreement). Another suggestion that the hospital CEOs and CFOs have opportunity to comment on proposal. Suggestion is to have small group develop proposal and then have another CHTF meeting to see a fully-developed issue brief on each. Payers would be participating in giving comments too.

Question posed to United on their view. Response is that United's negotiations with each facility determine the outcome of payment. Don't know corporate position on transparency of payment rates – but have been involved in transparency discussions in the past.

Comment from BCBSRI that price is fundamental to their competitive position.

Commissioner Koller stated that the next step is to convene a small group.

Public comment

Mark Crevier: Task Force is not paid to be here, working hard, and now coming to a stalemate. It's a good day for the plans – the last thing they want is transparency. The system is broken – only the payers are stable. Understand the need to have financially secure health plans, but there's not authority or regulations to make sure that providers are also secure. It's in hospitals' best interest to compete with each other and take each other's volume. If you look at the history of hospitals in RI, the newest hospital is Kent – everyone else is shaped by history. There is a misconception that if we put more money into the system, insurance rates will increase. Care New England is a large employer itself – rates aren't going up, thanks in part to employee wellness programs – there's enough money in the system now that it could go to providers without raising rates. Planning should absolutely happen – funded by foundations. The Task Force's energy level is waning – you'll have one more meeting, but don't think that we're doing anything to make the situation better.

Ed Quinlan: If this group is going to make recommendations to the administration, why would the administration submit a budget that reduces payments to hospitals by $35 - $50 million? The inconsistency is overwhelming.

Next steps
Set up a CHTF meeting in a month.